IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7005 1160 0000 1506 8837

January 31, 2008

Mary Ruth Butler, Administrator
Mountain Valley Care & Rehabilitation Center
601 West Cameron Avenue
Kellogg, ID 83837

Provider #: 135065

Dear Ms. Butler:

On **January 17, 2008**, a Recertification and State Licensure survey was conducted at Mountain Valley Care & Rehabilitation Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 13, 2008**. Failure to submit an acceptable PoC by **February 13, 2008**, may result in the imposition of civil monetary

penalties by **March 4, 2008**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **February 21, 2008 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **February 21, 2008**. A change in the seriousness of the deficiencies on **February 21, 2008**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 21, 2008** includes the following:

Denial of payment for new admissions effective **April 17, 2008**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 17, 2008**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 17, 2008** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **February 13, 2008**. If your request for informal dispute resolution is received after **February 13, 2008**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Loretta Todd

LORETTA TODD, R.N.
Supervisor
Long Term Care

LT/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135065	A. BUILDING _____ B. WING _____	01/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VALLEY CARE & REHAB CTR	601 WEST CAMERON AVENUE KELLOGG, ID 83837

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey of your facility. The surveyors conducting the survey were: Mark Sawmiller, RN, Team Coordinator Lea Stoltz, QRMP David Scott, RN Lorraine Hutton, RN Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined that the facility failed to ensure medication administration was performed according to accepted standards of practice by a LN not remaining with a resident to ensure medications were taken. This was true for 1 of 13 sample residents and 1 random resident (#11 and #16). The findings include: 1. Resident #11 was admitted to the facility on 10/10/06 with diagnoses of diabetes mellitus,	F 281	F-281 Resident # 11 was assessed and it was determined that resident was capable of self-administering meds once prepared by the Licensed Nurse. Physician's order will be obtained, and Care Plan updated to reflect this. Resident # 16 was assessed and it was determined that this resident was not a candidate to self-administer medications that were previously prepared by the Licensed Nurse. This has been communicated to Licensed Nurses. Facility's IDT will review other residents to identify those who may wish to self-administer medications. Residents who express a desire to self-administer medications will be assessed to determine if they are able to perform these tasks independently. Licensed Nursing Staff were in-serviced on 02/11/08 on need to supervise / observe residents while taking their medications unless that resident has been assessed and determined to be	

RECEIVED
FEB 14 2008
FACILITY

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marguerite Butler — TITLE: Executive Director — (X6) DATE: 2.12.08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 asthma, arthritis and hypertension On 1/16/08 at 7:30 a m Resident #11 was observed seated in a chair in her room A cup of pills was observed on the over the bed table. When asked if she was going to take her medications, she stated she took them with her breakfast, and the tray had not yet come The resident stated "It's my fault, I told her to leave them." The LN was not in the room during the observation. At 7:40 a.m the resident was observed taking her pills with the breakfast tray in front of her on the over the bed table. According to the 1/1/08 Physician's Orders, the resident received Toprol XL 100 mg, Cozaar 100 mg, (antihypertensives), Metformin 1000 mg (for diabetes), and Dyazide 25/37 5 mg (for edema) routinely at 8:00 a m The Administrator and DON confirmed on 1/17/08 at 9:00 a m that the resident was not assessed to, nor was there a physician order in place for self administration of medications. "Nursing Interventions & Clinical Skills, 3rd Edition" by Elkin, Perry, and Potter states regarding medication administration on p. 420, "Remain with the client until the medication is taken. Provide assistance as necessary. Do not leave medication at bedside without a prescriber's order to do so." After a review of the resident's medical chart, it was determined the facility had no physician order to self-administer medications	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* safe to Self-Administer their medications. DNS or designee will monitor through random observations to ensure nurse remains with residents while taking their medications unless the resident has been assessed to be able to do this independently. Findings will be reported to facility's Performance Improvement Committee for review and further recommendations.	02/21/08

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F 281	Continued From page 2 2. Random Resident #16 was admitted to the facility on 1/19/07 with diagnoses of lumbago, congestive heart failure (CHF), coronary artery disease, depression, deep phlebitis, panic disorder, hypothyroid, hyperlipidemia, and dementia On 1/15/08, at 8:10 a m , the surveyor observed an LN walk into the assistive dining room, deposit a plastic cup with oral medications in front of Resident #16, and then leave the dining room without speaking to the resident The surveyor then observed Resident #16 ingest the medications after the LN exited the dining room Physician recapitulation orders for Resident #16, dated 12/31/07, documented the resident's oral medications included Cymbalta, 60 mg, for depression and neuropathic pain; Synthroid, 0.088 mg, for hypothyroid; aspirin, 81 mg, for prevention of clots and cardiovascular accident; Hydrochlorothiazide, 75 mg, for edema; Lipitor, 10 mg, for hyperlipidemia; Aricept, 10 mg, for dementia; Coreg, 6.25 mg, for hypertension, and Oxycodone, 5 mg, for pain "Nursing Interventions & Clinical Skills, 3rd Edition," by Elkin, Perry, and Potter, states that regarding medication administration (p. 420), "Remain with the client until the medication is taken Provide assistance as necessary Do not leave medication at bedside without a prescriber's order to do so " A review of Resident #16's medical chart revealed the facility did not have a physician's order that directed self-administration of medications for the resident.	F 281		

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F 281	Continued From page 3 The administrator and DON confirmed on 1/17/08 at 9:00 a m that the resident was not assessed to, nor was there a physician order in place for self administration of medications	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 465 SS=D	483 70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the three washing machines for resident clothing were properly equipped with air gaps on their drains to prevent backflow. This had the potential to contaminate resident clothing being washed and posed a health hazard to laundry staff The findings include: On 1/16/08 at 10:55 am, the surveyor and Maintenance Director inspected the three washing machines for air gaps on their drains to prevent backflow into the washing machines Each drain extended below the top level of a drain trough There were visible water stains that were even with the top level of the trough. In the event that backflow from the drain at the bottom of the trough were to fill the trough, the washing machine drains lacked sufficient air gaps to prevent back siphonage into the washing washings. Resident clothing contaminated by backflow into the washers could have created a risk for cross-contamination, along with creating a potential health hazard for laundry staff handling	F 465	F-465 Drains on 3 washing machines were repaired to prevent backflow. Other drains that have potential to have backflow issues were evaluated and it was determined that no other issues was identified. Maintenance Director will monitor to ensure drains remain properly equipped to prevent potential backflow issues. This will be placed on facility's Preventative Maintenance Calendar. Findings will be reported to facility's Performance Improvement Committee for tracking / trending and further recommendations.	02/21/08

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F 465	Continued From page 4 contaminated clothing On 1/16/08 at 11:40 am, the Administrator was made aware of the lack of sufficient air gaps on the washing machine drains	F 465	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 468 SS=B	483 70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure that handrails were properly secured. This had the potential to affect all ambulatory residents. The findings include: On 1/15/08 at 9:00 am, the handrail across from the nurses station on the right side of the 300 hall entry way could be pulled loose from the wall approximately 1/4 inch on the end next to the hall. At 10:00 am on 1/15/08, two handrails near the Director of Nursing Services office could be pulled loose from the wall approximately 1/4 inch on the ends closest to the dining room. If the handrails were allowed to loosen further, they could potentially pose fall risk to ambulatory residents. On 1/15/08 at 10:15 am, the Maintenance Director was shown the loose handrails near the nurses station and Director of Nursing Services office. He indicated he would secure the handrails and stated, "I'll get on them right now."	F 468	F-468 Handrails identified during the survey were repaired at the time that they were identified as a concern. Maintenance Director evaluated other handrails and identified that there were no other handrails that needed to be repaired. Maintenance Director will monitor handrails through facility's Preventative Maintenance program. Findings will be reported to facility's Performance Improvement Committee for tracking / trending and further recommendations.	02/21/08

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State licensure survey of your facility The surveyors conducting the survey were: Mark Sawmiller, RN, Team Coordinator Lea Stoltz, QRMP David Scott, RN Lorraine Hutton, RN Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* RECEIVED FEB 14 2008 FACILITY STANDARDS	
C 389	02 120,03,d d. Handrails of sturdy construction shall be provided on both sides of all corridors used by patients/ residents This Rule is not met as evidenced by: Refer to F468 as it refers to handrails being properly secured	C 389	C 389 02.120,03,d Refer to F-468	02/21/08
C 745	02 200,01,c c Developing and/or maintaining	C 745	C 745 02.200,01,c Refer to F-281	02/21/08

Bureau of Facility Standards

Marybeth Butler — LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Executive Director

(X6) DATE: 2-12-08

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C 745	Continued From page 1 goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Refer to F281 as it relates to medication administration.	C 745	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	